FOR OFFICE USE ONLY

Date _____

Amount _____

APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

I. IDENTIFICATION

Name of Hospital _____

Address of Hospital _____

City/County/Zip _____

Telephone Number _____

Administrator _____

Date hospital began operation at current address _____

Date hospital began operation under current owner _____

II. CONTROL (Circle one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

Name and address of direct owner

_____

_____

_____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

(Over)

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

III. TYPE BEDS

TYPE BEDS	No. Beds Licensed	No. Beds Requested
Acute	_____	_____
Psychiatric	_____	_____
Chemical Dependency	_____	_____
Rehabilitation	_____	_____
Other _____		

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time.

I agree that this service and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel.

I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

_____	_____	_____
Signature of Authorized Representative	Title	Date

Return application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621